Palestinian mothers' perceptions of child mental health problems and services

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The aim of this study was to explore Palestinian mothers' perceptions of child mental health problems and their understanding of their causes; to determine Palestinian mothers' awareness of existing services and sources of help and support; to identify professionals in the community whom Palestinian mothers would consult if their child had mental health problems; and to establish their views on ways of increasing awareness of child mental health issues and services. Checklists exploring the above issues were completed by 249 Palestinian mothers living in refugee camps in the Gaza Strip. Palestinian mothers equally perceived emotional, behavioural and psychotic symptoms as suggestive of mental ill health in childhood. Mothers perceived multiple causes of child mental health problems, including family problems, parental psychiatric illness and social adversity. A substantial proportion (42.6%) had knowledge of local child mental health care services. Overall, mothers preferred Western over traditional types of treatment, and were keen to increase mental health awareness within their society. Despite a different cultural tradition, Palestinian mothers appear open to a range of services and interventions for child mental health problems. As in other non-Western societies, child mental health service provision should be integrated with existing primary health care, schools, and community structures.

Key words: Mothers, child mental health, child mental health services, Palestine

Socio-cultural factors play a major role in the presentation and recognition of child and adolescent mental health problems and disorders (1,2). Attitudes to child rearing and expectations of children's behaviour have been found to differ between cultural groups (3). Moreover, cross-cultural differences appear to be linked to more reporting of either internalizing problems such as withdrawal, somatic complaints and anxiety/depression symptoms in non-Western child populations, or externalizing problems such as attention problems and delinquent and aggressive behaviour in Western groups (4). Culture is not the only factor accounting for these differences. For example, child psychopathology may be mediated by socio-economic adversity across all cultural groups (1,5).

Cross-cultural differences appear to endure when people immigrate to different societies. There seem to be differences in parents' reporting of children's problems between the indigenous population and the ethnic minorities living in Western countries (6). Some studies have found a higher prevalence of psychiatric disorders within ethnic minority children living in the West, but these findings are far from conclusive, partly because risk factors have been found to have a different effect in different communities (7-9). The limited awareness of ethnic minorities about appropriate services in their new community may severely limit the utilization of such services (9).

There has been substantial research on the epidemiology of child psychiatric disorders across different cultures and societies (10). An early World Health Organization cross-national study, based on parent and teacher ratings of child behavioural and emotional problems, established a wide variation of prevalence rates (between 7 and 19% for parents, and between 4 and 14% for teachers) in Japan, China and Korea (11). This variation may reflect the measures,

definition and threshold of child mental health problems (12), or the discrepancy between informants, with parents being more likely to over-report behavioural (externalizing) and to under-report emotional (internalizing) symptoms (13). When psychiatric interviews were used or weighted prevalence rates of child psychiatric disorders were estimated, these were found similar to those in Western societies (around 10%), e.g. in studies in South India (14), Brazil (15), or the Middle East (16). These rates have been higher among clinical populations, such as children attending primary health care services in Nigeria (17).

Despite the increasing evidence on the prevalence of child mental health problems and disorders in non-Western societies, there has been limited research on how these problems are perceived by parents in different societies, and what types of supports, help and services they would wish to receive. In particular, it is unknown whether there are cultural and ethnic differences in parental beliefs about the causes of children's problems and appropriate interventions (18). Such knowledge is important in planning child mental health and related services, and was the rationale for this study among Palestinian mothers living in the Gaza Strip.

Traditionally, in the Arab world, political and religious forces have always been intimately intertwined, and Islam is a crucial factor in all aspects of life. In most Middle Eastern countries, until relatively recently, mental illness was thought to be due to possession by demons, failure to follow rituals, or fate (19). Nowadays, psychiatry is well established in Arab societies (20), though traditional and religious healers also play a major role in primary psychiatric care (21). Recent studies have found an increasing recognition by health professionals (e.g., in the United Arab Emirates) (16), and similar patterns and mechanisms of child psychopathology as in Western societies (e.g., in general

population studies in the Gaza Strip) (13,22). However, less is known on parents' awareness and perceptions of different services and sources of help for children with mental health problems, hence the rationale for this study.

METHODS

The aim of the study was to establish mothers' perceptions of child mental health problems, aetiology and methods of intervention. Based on the researched literature, it was hypothesized that: a) traditional Palestinian views of mental illness would be narrower than in the Western world, and only severe symptomatology such as psychosis would be considered as mental illness; b) parents would preferably seek the help of traditional healers rather than Western style treatments, as their awareness of available services is limited.

The provinces of the Gaza Strip comprise a narrow zone of land along the Mediterranean Sea, between Israel and Egypt. The Gaza Strip is 50 kilometres long and 5-12 kilometres wide. There are 808,000 registered refugees, over 55% of whom (443,000) live in eight refugee camps, and the rest live in the towns and cities of the Strip. The United Nations for Relief and Work Agency (UNRWA) provides education for 159,892 pupils, as well as health and relief services to refugees living inside and outside the camps. Within the refugee population, the birth rate is 55 per 1000, with a neonatal mortality rate of 20 deaths per 1000 live births, and an infant mortality rate of 33 per 1000 live births. The live expectancy is 71.7 years. Young people under the age of 15 years constitute 43.6% of the general population, and the average refugee family size is six persons (23).

The study was designed to survey the mothers of a cross-sectional sample of Palestinian children living in the El-Nusirate refugee camp in Gaza, which has a population of 44,685 (23). One section (locality) of the camp was selected. Every third household with children under the age of 16 years living in the camp locality was selected for the study (N=260). Eleven families refused to participate in the study, with the remaining 249 families taking part.

A checklist was devised on parents' perceptions of what constitutes child mental health problems, perceived causes of child mental health problems, appropriate services and interventions they would approach to seek help for child mental health problems, and ways of increasing awareness of child mental health problems. The list of the different services available to children and adolescents included governmental, United Nations, non-governmental and other services in the community. The list of types of treatment offered by the different organizations included religious, medical and psychological modalities.

As the aim of the study was not to establish rates of psychiatric morbidity in the sample, but rather to establish parents' perceptions of what constituted mental health problems, we opted not to use a rating scale of emotional and behavioural problems or a semi-structured diagnostic inter-view. Instead, the checklist included a range of emotional, cognitive and behavioural manifestations, which were described by the researcher to the mother. The mother then rated whether each manifestation constituted, in her opinion, a mental health problem (i.e., an undesirable symptom which might deviate from what is normal or expected, and which may require help or treatment in order to improve). Reports did not refer to individual children, although it is acknowledged that mothers' reports may have been influenced by their personal or their children's experiences.

Socio-demographic data on parental occupation, education, number of siblings and family income were collected from the mothers.

RESULTS

As shown in Table 1, despite families' low income and refugee status, parents had received different levels of education, possibly reflecting the relative stability of Palestinian families, which have been living in the same area for the last 50 years.

Tables 2 and 3 show how frequently the various emotional, cognitive and behavioural manifestations were perceived by the mothers as mental health problems in a child.

When asked about their opinion on the causes of child mental health problems, most mothers reported multiple

Table 1 Socio-demographic characteristics of the sample (N=249)

	N	%
Paternal employment status		
Unemployed	40	16.0
Unskilled worker	50	20.1
Skilled worker	49	19.7
Civil employee	96	38.6
Merchant	14	5.6
Paternal education status		
Illiterate	6	2.4
Elementary school	27	10.9
Primary school	56	22.5
Secondary school	68	27.3
Diploma	43	17.2
University	42	16.9
Post-graduate	7	2.8
Maternal employment status		
Housewife	222	89.2
Employee	27	10.8
Maternal education status		
Illiterate	30	12.0
Elementary school	68	27.3
Primary school	102	41.1
Secondary school	25	10.0
Diploma	1	0.4
University	23	9.2
Family monthly income		
Less than 300 US$	67	26.9
300-500 US$	125	50.2
More than 500 US$	57	22.9

Table 2 How frequently mothers perceived various emotional and cognitive manifestations as mental health problems (N=249)

	N	%
Phobias (excessive fears)	165	66.0
Somatic complaints	108	43.2
Depression	107	42.8
School refusal	75	30.0
Day time wetting of clothes	52	20.8
Suicidal thoughts	56	22.4
Suicidal behaviour	49	19.6
Inattention	146	58.4
Hallucinations	107	42.8
False beliefs	69	27.6

Table 3 How frequently mothers perceived various behavioural manifestations as mental health problems (N=249)

	N	%
Disobedience	174	69.9
Sleep problems	82	32.8
Fighting	123	49.2
Destructive behaviour	102	40.8
Outburst of anger	157	63.2
Verbal abuse of others	139	55.6
Lying	117	46.8
Physical abuse of others	119	47.8
Fire setting	76	30.4
Escape from home	71	28.4
Truancy from school	60	24.1
Drug use	39	15.6

reasons: 221 (89.1%) attributed them to family problems, 212 (85.5%) to parental mental illness, 208 (83.9%) to socio-economic adversity, 164 (66.1%) to accidents, 157 (63.3%) to genetic disease, 152 (61.3%) to organic brain lesions, and 86 (34.7%) to being "possessed".

When asked about their awareness of child mental health centres and services, 106 mothers (42.6%) were aware of them, with the vast majority (N=230, 92.7%) stating the need for such services. Seventy percent of mothers (N=174) said that they would take their children to a primary health care centre if concerned about any of the previous mental health problems, 158 (63.2%) would see a psychologist or psychiatrist, 131 (52.4)% a social worker, while 10 mothers (4%) would take their child for cauterisation (traditional Arab treatment).

When asked about their preferred type of treatment, 211 mothers (84.7%) stated that they would prefer some kind of "talking treatment" (psychotherapy), 157 (63.1%) would prefer medication, 152 (61.0%) treatment by recit-

ing the Quraan to their children, and 38 (15.3%) would take their child to a smoking setting to inhale Bokhour.

Finally, mothers were asked what could help children and parents to understand better the nature of mental health problems, and identify appropriate services within their society. Most mothers (N=226, or 91.1%) mentioned series of lectures for teachers and parents, 218 (87.9%) suggested TV programmes directed at children and adolescents, 199 (77%) regular leaflets containing information and advice about child mental health problems, and 167 (67.3%) public meetings between parents and professionals.

DISCUSSION

Child mental health problems and disorders constitute an increasingly wide concept, with variable perceptions and attributions by parents and professionals. Despite some evidence of similar diagnostic patterns and prevalence across different cultural and ethnic groups, there is limited knowledge on the impact of cultural factors on such perceptions (5,24). This study explored this question among Palestinian mothers living in a refugee camp in the Gaza Strip. Contrary to our hypothesis, mothers' perceptions of child mental health problems, their causes and preferred types of services were broad and not substantially different from those within Western societies.

Mothers equally perceived emotional, behavioural and psychotic symptoms as representing mental health problems. The value traditionally attributed to discipline within the family and extended community may explain the high rate of mothers considering disobedience and outburst of anger as potentially deviant. The relatively low percentage of mothers perceiving suicidal thoughts or acts as representing mental health problems may reflect religious beliefs, and indeed low self-harm and suicide rates within the general population (20). This is in contrast with the perceptions not only of Western but also of Asian parents (3,9).

While a large proportion of mothers considered family factors to be a cause of child mental health problems, equally large numbers mentioned social adversities, and a substantial minority mentioned possession by evil spirits. Interestingly, most mothers considered several possible causes, i.e. cultural perceptions or attributions were not incompatible with environmental, genetic or organic explanations. Again, the importance of the nuclear family within the Palestinian society did not prevent mothers to consider family factors in the development of child mental health problems. Indeed, in a Lebanese study, Zahr (25) found family-related factors to mediate external stressors and child psychopathology.

Also contrary to our hypothesis, Palestinian mothers reported that they would contact health centres or specialist mental health professionals rather than traditional healers. This may be in contrast with other contemporary Arab societies, where traditional healers still play a significant role (21). This finding may be explained by the participants'

educational status. The role of primary health services, as well as schools, is particularly important for the detection of child mental health problems in developing countries, with referral of the more severe disorders to the limited specialist child mental health services (26,27).

The proportion of Palestinian mothers who appeared aware of local child mental health services may be considered high, even compared with findings from Western countries (28). As the locality of the study was covered by a community mental health centre for adults and children (29), this frequency may be lower in other areas of the Gaza Strip. However, even mothers not aware of the local service acknowledged the need for such provision. Within these "Western style" services, Palestinian mothers reported their preference for "talking treatment" (a loose definition of psychotherapy) and pharmacological treatment. Religious or cultural sources of help were considered important (such as reciting the Quaaran and attending smoking settings), but again not incompatible with mental health interventions. Interestingly, mothers rated positively the opportunity to find out more on child mental health issues and services through awareness meetings, talks and information material from professionals. We have recently established similar wishes for community psychoeducation among Asian families living in the UK (3).

Establishing parents' views and expectations of child mental health services is as important in developing countries as in Western societies. This is one of the factors that should be considered in setting priorities and rationalizing small service resources. Assessment of local needs and maximization of existing community services and other sources of support are essential (30). In addition, these findings support the importance of flexibility in the types of services and interventions. A "help-seeking" model of offering choice from identification to treatment (31) would be useful in any cultural and social context.

There were several limitations to this study. The sample of mothers may not be representative of all Palestinian society, or of other Arab populations. Although the aim of the study was not to establish prevalence of child psychiatric disorders, the checklist items on child psychopathology were not validated and could have been under- or over-reported by respondents. Similarly, a semi-structured interview, rather than a checklist, would have resulted in a better understanding of mothers' views, experiences and attributions, although a qualitative approach would have constrained the sample size. Future research should expand this information on service users' perspectives, which should be triangulated with children/young people's and professionals' perceptions.

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